



PHYSICIAN'S CERTIFICATE FOR DISABILITY BENEFITS

**IMPORTANT: READ INSTRUCTIONS BELOW REGARDING THE ATTACHED FORM
AND RETURN TO VPA IMMEDIATELY.**

INSTRUCTIONS FOR PHYSICIAN:

Your patient is requesting that you complete the attached **Physician's Certification** form to certify his/her disability. Unless each question is answered, we cannot process benefit payments and your patient may not get paid.

Please complete the attached statement **immediately** and **fax it to (818) 591-7664**.

If you would prefer to phone in the information, or if you have questions regarding this form, please **call (818) 591-2772** to speak to a VPA Customer Service Representative between the hours of 6:00 a.m. to 4:45 p.m., Pacific Time.

INSTRUCTIONS FOR EMPLOYEE:

It is very important that you have your physician complete the attached **Physician's Certification** form in a timely manner. VPA cannot process your request for disability benefits without proper documentation from your physician.

Have your physician's office follow the instructions above, or request they provide you a copy of the completed form instead so you can **fax the form to (818) 591-7664**. You may also mail the form to VPA, Inc. / PO Box 9830 / Calabasas, CA 91372-0830, if necessary.

If you have questions regarding this form, please **call (818) 591-2772** to speak to a VPA Customer Service Representative between the hours of 6:00 a.m. to 4:45 p.m., Pacific Time.



Physician's Certification for Disability Benefits

Your patient's income is directly related to the timely receipt of this information. **Complete and Fax to (818) 591-7664**

Patient's Name:		Phone:	Claim Nbr or Last four digits of SSN:
Patient's Date of Birth:		Medical Records Nbr (If applicable):	
Employer Name:			

Patient Information (MANDATORY):

Primary CPT/ICD Code	Diagnosis Description			
Secondary CPT/ICD Code	Diagnosis Description			
Is this condition work related?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Accident related?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Accident:	
Physical Exam Findings/Symptoms				
Diagnostic Tests and Results				
Current Medications				
Assistive devices in use by patient (Check all that apply)	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Other:			
Disability Start Date	Disability End Date	1 st Treatment Date	Last Appointment Date	Next Scheduled Appt. Date

Complete this Section if Pregnancy Related:

Actual Delivery Date (or EDC)	<input type="checkbox"/> Vaginal delivery	Post Delivery Recovery Period: _____ Weeks
	<input type="checkbox"/> C-Section	

Complete this Section if Patient is Hospitalized or Surgery Performed or Planned:

Date admitted	Date discharged	Surgery date	
Hospital/Surgical facility name	City	State	Telephone number

Complete this Section for Physical and/or Mental Limitations :

What limits the patient's ability to do their job?			
Is patient on light duty?	<input type="checkbox"/> No <input type="checkbox"/> Yes	→ Light duty start date: _____ Light duty end date: _____	
List light duty restrictions:			
Restricted hours start date	List restricted hours	Restricted hours end date	

Complete this Section if the Patient has been Referred to Another Physician or Provider:

Has patient been referred to another physician or other provider for this illness?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
	Referred Physician's Name:	Specialty	Office Number

Physician Information (All Information in this Section Must be Completed and Form Signed Below):

Physician's Name (print)	Specialty	License #	Licensing State
Select Appropriate Professional Designation	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> Ph.D. <input type="checkbox"/> CNM (CNM may only certify 4 weeks pre-EDC and 6/8 weeks post partum) No other providers may certify or extend a disability.		
Address	City	State	Zip
Office Number	Fax Number	HMO Name/# (If applicable)	

I hereby certify the above statement in my opinion truly describes the patient's condition and the estimated duration thereof.

X Physician's Signature:	Date:
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FAX COMPLETED FORM TO **818-591-7664** OR MAIL TO VPA INC. / PO BOX 9830 CALABASAS, CA 91372-0830

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